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Psychological Problems of Adolescent Sexuality

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There always have been psychiatric problems associated with adolescent sexuality. The very nature of schizophrenia, which is hardly ever seen before puberty and is generally ushered in with a divorce from reality and a preoccupation with fantasy, usually sexual fantasy, is itself indicative of the vulnerability of the adolescent personality to the challenge of adult sexuality.

Until recent years, the major conscious sexual outlet for adolescents in our culture was masturbation and indeed, compulsive masturbation was at one time regarded as a cause of schizophrenia though the fantastic, but more probably, fantasized experiences of Mr. Portnoy have cast some doubts on this assumption. It should be noted that parents and teachers did regard preoccupation with these matters as harmful to the educational and developmental process and even equated the sin of Onan with masturbation, though every Biblical scholar knows that Onan's sin was, in fact, coitus interruptus.

Any attitude which would substitute hard physical and mental work for sexual preoccupation in adolescence, and one which was strongly recommended by that great physician, Sir William Osler, is now dismissed as being positively harmful with no weightier argument offered than the label "Victorian." That the Victorians, with their dedication to hard work and their allegiance to a strong religious ethic developed the world and laid the foundations for the under-developed countries to enter the comity of nations; that they practiced philanthropy on an unprecedented and unsurpassed scale; that they reared large families and gave their sons and daughters to world causes — all these are conveniently forgotten or ignored. Everything Victorian must be bad, especially its disapproval of pre-marital and extra-marital sex.

When one therefore considers adolescent sexuality, one must bear in mind that adolescents are vulnerable people and that they are now

living in a society where educational accents have shifted. They are likely to be exposed to sexual education designed to "turn them on," while their parents and grandparents were "turned off." Fantasies have given way to factual experience and where fantasies are fostered, they are likely to be heavily contaminated with perverse practices. The adolescents of a previous generation also had masturbatory fantasies, but these usually held a tenderness, respect and even dedication for the fantasized love object.

But adolescents then had very little money and what they had was usually spent in a manner approved by their parents. Now youngsters have money and are no longer under parental control. This immediately exposes them to merchandisers who enjoy the approval of social scientists and even a number of our medical colleagues. The situation is further complicated by a systematic distortion of the meanings of terms and one really requires a special glossary to understand what is being said. Here are a few of these terms and what they really mean:

- Family Planning Centers — Off-license contraceptive premises.
- Love — Sexual stimulation with man, woman, beast or thing.
- Therapeutic Termination of Pregnancy — Abortion on demand.
- Gender Identity — Homosexuality or lesbianism.
- Danger of Pregnancy — Abortion is safer.
- Pregnancy Advisory Service — Abortion clinic.
- Charitable Status — Abortion fees are higher than a reputable hospital.
- True Art — Pornography.
- Art for Connoisseurs — Hard porn, including all perversions.
- Mature Relationship — Going steady for the past week.
- Age of Consent — Puberty or before.
- Transvestism — Minor pretence.
- Transsexualism — Major pretence.

That youngsters are generally sensitive and vulnerable on sexual matters is given scant consideration, for the Food and Drugs Act does not extend to this area and merchandisers can peddle their pills with impunity. I use the word "peddle" advisedly, for there is more profit to be derived by hooking 100 girls on the Pill than in achieving 100 adolescent contacts with heroin. In the latter instance, the vast majority will be unhooked in a matter of months, but in the case of the Pill they stay hooked until well after the menopause, for it also alleged to prevent senile vaginitis and secure sexual delights to the grave. It is, therefore, for many a life-time commitment.

Side effects, even dangerous ones, were dismissed as irrelevant, for pregnancy was regarded as the real danger. Cerebral and coronary thrombosis resulting in a substantial number of deaths were at first denied as having anything to do with the Pill and were later concealed by statistical jargon. The old clinical adage that, for the unfortunate individual, the devastation is 100% was ignored and one was given the

risks of pregnancy in general terms but not of that particular patient's pregnancy.

Why should a merchandiser ignore a large slice of a market, viz. those between the ages of 12 and 16 years which would provide him with a longer production run, especially when all enlightened agencies such as TV, radio, the press, women's magazines, the with-it clergy, our permissive brothers and sisters in medicine and hordes of social scientists all proclaim its benefits?

Even if adolescent sex were desirable, and I have not conceded this, it is contrary to our understanding of the maturational process to equate psychological maturation with the physical, or for that matter, with chronological age. We accept that alcoholic drinks should not be served to young persons, but sex is a different matter. A paradoxical situation has arisen in that society has tended more and more to detain young people in a state of dependence with increasing years of schooling and special courts and institutions for juvenile offenders, yet in sexual matters the age of maturity is being constantly reduced so that one can be faced, as I was recently, with a girl of 14 years who was living with her "common-law" husband. How one can be in breach of the criminal law and yet be in accordance with common law defies my understanding.

The cinema today, which is frequented mainly by adolescents, not only portrays erotica, but features perverse practices with liberal doses of sadism and masochism. Every father is raping his daughter and every mother is either cuckolding or having an incestuous relationship with her son, or both. Even the domestic pet is not safe from sexual advances. Then there is the social climate where marriage is no longer regarded as a permanent institution and the home can mean processions of fathers and mothers, while even the more stable marriages are bolstered by wife-swapping parties.

One may ask, how can adolescents survive this onslaught and not break down? That many, if not most, do not, is an eloquent tribute to the resilience of the human organism. But some do.

Firstly, there are the sensitive who are offended by all that surrounds them and withdraw into a fantasy life, and are eventually divorced from reality to join the ranks of the schizophrenics.

Secondly, there are those whose psychosexual development is arrested. Sexual orientation in our culture is a tender plant and in the psychosexual development of the child all go through a homosexual phase which in the majority yields to heterosexual interests, though in varying degree. We do talk of sexual orientation being fixated at certain levels and while there is no certainty regarding the fixating factors, some are accepted as more contributory, e.g., an over-solicitous if not seductive mother, or exposure to homosexual experience. In a society where heterosexuality is regarded as the norm and homosexuality as a perversion, there is social pressure towards the achievement

of full heterosexuality. Many young men would therefore enter heterosexual society even though they had reservations regarding their competence. Most found the experience not too formidable and worthy of repetition. If homosexuality is allowed to compete on more than equal terms — and through its heavy representation in the mass media and the present social climate, it has this advantage — then many who would otherwise succeed are prevented from achieving full heterosexuality.

The American Psychiatric Association has joined the homosexual lobby, for on December 15, 1973, it discontinued the listing of homosexuality as a mental disorder in its official nomenclature and replaced it with "sexual orientation disturbance" but only "for individuals whose sexual interests are directed primarily towards people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation."

This definition specifically excludes homosexuality as a pathological process. Yet there are many psychiatric disorders which would meet these qualifications such as paranoid states, the flamboyant hysteric and the psychopathic personality who, by definition, does not suffer from his disability but makes others suffer. Then there are the sadists, the masochists, the arsonists, the flashers, the streakers, the anorexia nervosas, the alcoholics, the drug addicts, the obese, the hypochondriacs, the self-mutilators, etc. Why a pathological sexual orientation should be specifically given this dispensation by an association which in other respects is expanding the application of the definition of mental abnormality is a most pertinent question. Perhaps one answer is that homosexual behavior in certain jurisdictions is no longer an offense and so we have an interesting situation in that by making an act legal, that act need no longer be considered as having any contributory psychiatric factor. If the law "progressed" so that burglary was no longer regarded as a crime but a form of redistribution of wealth, and murder a form of population control, then psychiatry would begin to show interest in those who did not indulge just as it is now becoming preoccupied with those doctors who have a strong aversion to abortion.

But what of the specifics? Does adolescent sexuality do harm? There is no evidence that it does any good and if it does harm, in many instances that is not sufficient to bring the practitioner to the attention of a psychiatrist. In some instances it does do material harm but here we are faced with a difficulty, for medicine is now so statistically-minded that it can only see undesirable side effects in terms of prevalence and incidence. Samples, usually random ones, are exposed to a certain situation. Casualties are counted and if none or few are found the product, experience or what-have-you is pronounced safe. This method of assessment has pronounced every drug with subse-

quently proven dangerous side-effects, including thalidomide perfectly safe.

Fortunately there is a much older and more reliable method of assessing undesirable side effects and that is the reporting system. Doctor A reports a couple of instances, Doctors B and C confirm and Doctor D, after a more intensive study, shows that it is no accident and that the undesirable side effect is closely related to the drug or experience. A collecting agency for these side effects would get the answer more effectively and the Safety of Medicines Commission in Britain lays greater store on this method than on the formal controlled drug trials. Unless serious side effects were in the region of one in thirty, clinical trials would not be capable of demonstrating it. A condition like a post-abortion psychosis which does not occur more often than 1 in 800 to 1,000 would not be, and in fact has not been, recognized by this method. It would require a series of not less than 10,000 abortions matched with 10,000 controls who had not been aborted to get at the truth. This has never been done and it is not for want of abortion material, for individual psychiatrists are seeing more and more post-abortion psychoses, while those doing the controlled trials declare that they do not exist. Similarly with psychiatric hazards of adolescent sexuality.

The clinical groups can be divided into

- 1) those who indulge on a basis of instability;
- 2) those who are rendered more unstable by the experience.

These two groups are not mutually exclusive for one might reasonably expect that those who indulge on a basis of instability are rendered more unstable by the experience.

The following are the clinical categories of unstable people who are likely to indulge in sexual behavior:

- 1) **The schizoid and the schizophrenic** — These are not merely shy adolescents who, once launched on a course, will cope adequately. They are generally young people whose problems in psychosexual development are contributory to their psychiatric disability and for whom casual sexual relations could be and frequently are an aggravating factor.
- 2) **The depressed patient** — An abnormal appetite for affection is a frequent element in the make-up of such patients and in the intermediate stages they may seek sexual adventures or are prepared to comply with sexual demands if this is the price for companionship and affection.
- 3) **The phobic patient** — Lack of confidence with fear of venturing alone or even being left alone are common symptoms in this condition. An escort is therefore essential for them to function adequately, and if the price is sexual intercourse, so be it.

The last two categories are quite common and the first is not rare for it is generally held that the incidence of schizophrenia is 0.8% of

the population. So, whatever immunity the rest may bear, there is a sizeable proportion of vulnerable young people who are being encouraged to behave sexually in a manner which exposes them to potential harm and many will be precipitated towards a psychotic state.

I shall not deal with those who do not break down overtly but, once committed to casual sexual relations, adopt the mores associated with this life style and swell the ranks of the drop-outs; or those whose code is so offended by their conduct that they are overwhelmed with shame and guilt and underachieve in the business of life; or those who in casual and impermanent relationships find that the experience falls far short of what they had been led to anticipate and develop an antipathy to sex and mating which may arrest their psychosexual development and even fixate them at a homosexual level.

But homosexual fixation now has an entirely different connotation. It is, in certain quarters, regarded as a norm so when we talk of adolescent sexuality, homosexual experience must be given similar emphasis to the heterosexual. Even the physical risks are the same, for primary chancres are as commonly derived from homosexual activities as from heterosexual ones, while the present preoccupation with oral sex has increased the incidence of tonsillar primaries in both sexes. At one time adolescent exposure to homosexual behavior was generally a transient episode which soon gave way to heterosexual interests, but this is no longer so and early commitment is now regarded as total and permanent.

Whether this is a psychiatric hazard or not may be debated by some, but if a young person who, if only left alone, would spontaneously graduate to heterosexual orientation is actively discouraged from doing so, then one can only see this as interference with normal sexual development. Furthermore, even now, homosexual (and that includes lesbian) relationships do not enjoy the permanence of heterosexual ones so the vast majority are committed to a life-style of casual and temporary affairs with promiscuity dominant.

Even the practicing homosexual who, in response to social pressures generally sought help and not without success, is now regarded as a life-long member of a group with increasing influence. Some churches have already conceded them "marriage services." That their official bodies play a prominent part in the pro-abortion lobbies makes sense. Babies have no place in their "brave new world."

The extension of permissiveness from homosexual behavior and recruitment to transvestism and transsexualism raises other problems. Young schizophrenics are frequently confused over their gender identity. In therapy, their physical status is a useful fixed point of reference and one could always use this to help the patient towards an appreciation of reality. With transsexual operations being freely

recommended and being awarded legal recognition, these schizophrenic patients are placed in a most difficult situation. They are genuinely, though psychotically, concerned with their gender identity and indeed some do castrate or mutilate themselves. How does one now deal with their request for a "sex-change" operation? We now have the paradoxical situation that if an individual is really mentally disturbed over his gender identity, it would be bad medical practice to subject him or her to reconstructive surgery, but an individual who is not mentally ill can have the operation on psychiatric grounds.

Perhaps it is not so strange when one considers that upwards of 95% of all legal abortions are done on psychiatric grounds, whereas it has been adequately demonstrated that those who are at greatest risk in terms of psychiatric sequelae of abortion, are those with a previous history of mental illness.

I have only pointed out some of the nonsense. Doctors must use their influence with the public and politicians to stop it.

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